

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

CERTIFICATE OF DEATH

Reg. Dist. No.

13595

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			c. LENGTH OF STAY IN 1b 8 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Martha Middle E Last Abrahams				4. DATE OF DEATH Month 12 Day 23 Year 19 59			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1870		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas C. McCracken				14. MOTHER'S MAIDEN NAME Martha Browne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Howard Abrahams North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Interstitial Cystitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Hour o. m. p. m. - 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) -		(County) -	(State) -
21. I certify that I attended the deceased from June , 1952, to 23 Dec , 1959, that I last saw the deceased alive on 23 Dec , 1959, and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 12/23/59							
ACTUAL SIGNATURE Klaus H. Huebner		M.D. North East, Md		PHYSICIAN'S NAME (Type) Klaus H. Huebner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-26-1959	22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

CERTIFICATE OF DEATH

13596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 EIKTON</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lydia GREENE Bailey</u>		4. DATE OF DEATH Month Day Year <u>12 - 8 - 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John GREENE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-871</u>	
17. INFORMANT <u>MARTHA WALLS</u>		Address <u>323 Curtis Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Disease</u> DUE TO (c) <u>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 yr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 1959, to <u>Dec 8</u> , 1959, that I last saw the deceased alive on <u>12/3</u> , 1959, and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/8/59</u>			
ACTUAL SIGNATURE <u>James J. Greenwald</u> M.D.		PHYSICIAN'S NAME (Type) <u>James J. Greenwald M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CECILTON, Cecil Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Levie Hoag Balderston</u>				4. DATE OF DEATH <u>Dec.</u> Month <u>26</u> , Day <u>19</u> , Year <u>59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 / 8 / 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Balderston</u>				14. MOTHER'S MAIDEN NAME <u>Myra Atwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>300-01-9337</u>			
17. INFORMANT <u>Mrs. Anna Balderston</u>				Address <u>Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X</u> DUE TO <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u> </u> (c) DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anteriorly to Central does as Profusion's Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 19</u> , 19 <u>59</u> , to <u>Dec. 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>59</u> , and that death occurred at <u>MDA</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 B. MAIN ST. ELKTON, MARYLAND</u> DATE SIGNED <u>12/26/59</u> ACTUAL PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends-Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Colora Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. M. - Melba Rising Sun Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth: <u>10-11-1917</u> Sex: <u>Male</u> Race: <u>White</u> Marital Status: <u>Single</u> Occupation: <u>Student</u> Usual Residence: <u>1010 N. E. St. Baltimore, Md.</u> Date of Death: <u>10-11-1917</u> Place of Death: <u>Home</u> Cause of Death: <u>Heart Disease</u> Immediate Cause: <u>Myocardial Infarction</u> Underlying Cause: <u>Coronary Artery Disease</u> Contributing Cause: <u>None</u> Duration of Illness: <u>None</u> Date of Burial: <u>10-12-1917</u> Place of Burial: <u>Greenwood Cemetery, Baltimore, Md.</u> Name of Undertaker: <u>John J. Williams</u> Signature of Physician: <u>[Signature]</u> Signature of Registrar: <u>[Signature]</u> Date of Registration: <u>10-12-1917</u> Registrar's Office: <u>Baltimore, Md.</u>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake			c. LENGTH OF STAY IN 1b all life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. H.V. Davis Office				d. STREET ADDRESS Canal St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Timothy Middle Banks Last Banks				4. DATE OF DEATH Month 12 Day 8 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-58		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 2 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James D. Bedwell				14. MOTHER'S MAIDEN NAME Mary Ellen Banks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Mary E. Bedwell, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub dural hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell backwards and hit the floor					
20c. TIME OF INJURY Month, Day, Year 9-15 a. m. 12 8 19 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chesapeake City Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		22d. LOCATION (City, town, or county) (State) NR. CHESAPEAKE CITY Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS ELKTON Md.		24a. REC'D BY REGISTRAR DATE DEC 15 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1955

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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CERTIFICATE OF DEATH

13599

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Penna. b. COUNTY Chester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, Md. | | c. LENGTH OF STAY IN 1b
9 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
V. A. Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROY R. CAMPBELL | | 4. DATE OF DEATH
Month December Day 4 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-11-20 |
| 9. AGE (In years last birthday)
39 yrs. | | 10. IF UNDER 1 YEAR
Months 39 Days 0 Hours 0 Min. 0 | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Aberdeen Pr Gnd | |
| 11. BIRTHPLACE (State or foreign country)
Nottingham, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Clarence Campbell | | 14. MOTHER'S MAIDEN NAME
Ida McCall | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
198-10-5720 | |
| 17. INFORMANT
V. A. Hospital, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG - Anaplastic
DUE TO (b) 163X
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12:35 A.M. to 9:35 A.M. and that death occurred at 9:35 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE J. L. Garey M.D. VAH., Perry Point, Md. DATE SIGNED
PHYSICIAN'S NAME (Type) J. L. GAREY, MD Clinical Pathologist. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Buried | Dec 8 1959 | Oxford Cem. | Oxford, Chester Co Pa |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lila Patterson, Perryville, Md | | 24a. REC'D BY REGISTRAR
DATE 12/4/59 | 24b. REGISTRAR'S SIGNATURE
J. M. LOKEMAN
<i>Arthur L. Knead</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13626

CERTIFICATE OF DEATH

Reg. Dist. No.

13600

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesapeake City | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Morgan Nursing Home | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Chesapeake City | |
| | | d. STREET ADDRESS
/ | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Zachary First Taylor Middle Cooling, Jr. Last | | 4. DATE OF DEATH
Month Dec. Day 12, Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Apr. 28, 1880 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. U.S. Govt. | | 10b. KIND OF BUSINESS OR INDUSTRY
Govt. | |
| 11. BIRTHPLACE (State or foreign country)
Chesapeake City, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Zachary T. Cooling, Sr. | | 14. MOTHER'S MAIDEN NAME
Josephina Loveless | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
169-20-1497 | |
| 17. INFORMANT
Mrs. Marie S. Cooling, Chesapeake City, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 162.1 Bronchiogenic carcinoma with metastases
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
about 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 30, 19 59 to Dec. 12, 19 59, that I last saw the deceased alive on Dec. 8, 19 59, and that death occurred at 6:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
S. Ralph Andrews, Jr. | | ADDRESS (Street, city or town, state)
233 E. Main St. DATE SIGNED
12/12/59 | |
| PHYSICIAN'S NAME (Type)
S. Ralph Andrews, Jr., M.D. | | Elkton Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/15/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State)
Nr. Chesapeake City, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Pippin Funeral Home | | ADDRESS
Elkton, Md. | |
| 24a. REC'D BY REGISTRAR
DEC 21 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627

CERTIFICATE OF DEATH

Reg. Dist. No.

13601

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point
c. LENGTH OF STAY IN 1b
15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
607 Ancosita Ave., N.E.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
James
Middle
N
Last
Cornnor | | 4. DATE OF DEATH
Month
12
Day
12
Year
19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-9-15 |
| 9. AGE (In years last birthday)
44 | | 10. IF UNDER 1 YEAR
Months
9
Days
12
Hours
59
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Porter | | 10b. KIND OF BUSINESS OR INDUSTRY
Not Ascertainable | |
| 11. BIRTHPLACE (State or foreign country)
Copes, S.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Cornnor | | 14. MOTHER'S MAIDEN NAME
Katie Kitt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW II | |
| 17. INFORMANT
Not Ascertainable | | Address
Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
443x Azotemia, uremia (Clinical)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
Hypertensive Cardiovascular disease
DUE TO
(c)
Unkn. | | INTERVAL BETWEEN ONSET AND DEATH
7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis, generalized, severe | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.
VA 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that / attended the deceased from 11-27- 19 59 , to 12-12 19 59 , and that death occurred at 10:35A M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED
VA Hospital, Perry Point, Md. 12-12-59 | |
| ACTUAL SIGNATURE
J. L. Garey | | M.D.
VA Hospital, Perry Point, Md. | |
| PHYSICIAN'S NAME (Type)
J. L. GAREY, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
12-16-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National Ceme. | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John S. Stewart | | 24a. REC'D BY REGISTRAR
DATE DEC 16 '59 | |
| ADDRESS
30-H State | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13602

13616

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. LENGTH OF STAY IN 1b
all life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
21 Elkton | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
520 North St. | | | | d. STREET ADDRESS
520 North St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle O Last Dean | | | | 4. DATE OF DEATH
Month 12 Day 2 Year 19 59 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-11-1870 | | 9. AGE (In years last birthday)
89 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ship Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Delaware | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Dean | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Oliver | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
222-07-0228 | | 17. INFORMANT Address
Ralph Dean, 520 North St. Elkton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE R.C. Dodson M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) R.C. Dodson | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/5/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Elkton Cemetery | | 22d. LOCATION (City, town, or county) (State)
Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
PIPPIN FUNERAL HOME | | | | 24a. REC'D BY REGISTRAR
DEC 8 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Evans | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-------------------------------|--|----------------------|--|-------------------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John | | Male | | 20 | | 1910 | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| Maryland | | Baltimore | | Diphtheria | | Natural | |
| Occupation | | Education | | Previous Illness | | Injury or Poison | |
| Student | | High School | | None | | None | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| J. H. Smith | | W. B. Jones | | T. C. Brown | | A. D. White | |
| Date of Examination | | Time of Examination | | Place of Examination | | Signature of Deceased | |
| 1910 | | 10:00 AM | | Baltimore | | None | |
| Signature of Physician | | Signature of Nurse | | Signature of Hospital | | Signature of Family | |
| D. E. Green | | M. L. Black | | St. Mary's Hospital | | J. K. Lee | |
| Signature of Undertaker | | Signature of Burial | | Signature of Cremation | | Signature of Other | |
| F. G. Hall | | Catholic | | None | | None | |
| Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Witness | |
| H. I. King | | J. L. Scott | | J. H. Smith | | A. D. White | |
| Date of Registration | | Time of Registration | | Place of Registration | | Signature of Deceased | |
| 1910 | | 11:00 AM | | Baltimore | | None | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

Reg. Dist. No.

13628

| | | | | | |
|---|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>
c. LENGTH OF STAY IN 1b <u>22 yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13. S. Walnut St.</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>
d. STREET ADDRESS <u>13. S. Walnut St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Cornelia</u> <u>McChesney</u> <u>Dunn</u>
First Middle Last | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>9</u> Year <u>1959</u> | | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-8-1878</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Abingdon, Va.</u> |
| 13. FATHER'S NAME
<u>Edward Samuel Haney</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Craig Dunn</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
<u>Mrs. R.C. Dodson, Rising Sun, Md.</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture Left femur</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Myocarditis</u>
(c), stating the underlying cause lost. DUE TO | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fell at side of bed</u> | | |
| 20c. TIME OF INJURY Month, Day, Year <u>8:30</u> <u>12-9-1959</u>
Hour o. m. p. m. | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | |
| 20f. (City or town) <u>Rising Sun</u> (County) <u>Cecil</u> (State) <u>Md.</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<u>R.C. Dodson</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>R.C. Dodson</u> | | | DATE SIGNED
<u>12-9-59</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Dec. 12, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Sinking Springs Cem.</u> | |
| 22d. LOCATION (City, town, or county) <u>Abingdon</u> (State) <u>Va.</u> | | 24a. REC'D BY REGISTRAR
<u>DEC 11 '59</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. Earl Tyson</u> | | | 24b. REGISTRAR'S SIGNATURE
<u>Orlinda S. Hand</u> | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

13629

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
New York City, New York b. COUNTY
New York City 69X-3 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN lb
5 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
KATHLEEN M. FAHEY | | 4. DATE OF DEATH
Month Day Year
December 17 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/30/09 |
| 9. AGE (In years last birthday) yrs.
50 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
50 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY
Private | |
| 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Michael Fahey (Deceased) | | 14. MOTHER'S MAIDEN NAME
Catherine Daly (deceased) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepato-renal syndrome
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia, bilateral, unresolved
DUE TO
(c) Cerebral hemorrhage due to jaundice | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 17 1959 to December 17 1959 and that death occurred at 2:35 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
V.A. Hospital, Perry Point, Md. 12-18-59 | | | |
| ACTUAL SIGNATURE
L. G. CIAN | | PHYSICIAN'S NAME (Type)
Staff Surgeon | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
12/19/59 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
Calvary | | 22d. LOCATION (City, town, or county) (State)
New York | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son | | 24a. REC'D BY REGISTRAR
DATE DEC 29 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12628

New York City, New York

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13605

13630

| | | | |
|--|------------------------|--|------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 1 Month | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILSON J. GRAFTON | | 4. DATE OF DEATH Month Day Year December 1 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 2, 1896 |
| 9. AGE (In years last birthday) yrs. 63 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger | | 10b. KIND OF BUSINESS OR INDUSTRY Home Remodeling | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN A. GRAFTON | | 14. MOTHER'S MAIDEN NAME ANNE E. THOMAS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes WW-1 | | 16. SOCIAL SECURITY NO. 219-14-2461 | |
| 17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 154x Adenocarcinoma of the rectum with obstruction of the terminal ileum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 1, 1959, to December 1, 1959, and that death occurred at 12:15 AM from the causes and on the date stated above. | | 22. ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE J. L. GAREY M.D. V.A. Hospital, Perry Point, Md. 12-1-59 | | | |
| PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist | | | |
| 22a. BURIAL, CREMATION, RE MOVAL (Specify) Burial | | 22b. DATE THEREOF 12-4-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Centre Cemetery | | 22d. LOCATION (City, town, or county) (State) Forrest Hills, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HARKINS FUNERAL HOME, Delta, Penna. | | 24a. REC'D BY REGISTRAR DATE DEC 3 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kins | |

CERTIFICATE OF DEATH

13430

Geoff



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at Point

Reference to the death record

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13606

13617

| | | | |
|---|---------------------|--|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY CECIL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. LENGTH OF STAY IN 1b 5 YRS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY JANE Middle HAMMOND Last | | 4. DATE OF DEATH Month 12 Day 17 Year 19 59 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 23, 1904 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 11. BIRTHPLACE (State or foreign country) DELAWARE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SAMUEL MEDKEFF | | 14. MOTHER'S MAIDEN NAME IDA MAY BELL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. LILLIAN BYWATER SEATTLE, WASH. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 527.0 DUE TO Broncho pneumonia
(b) Post-operative Atelectasis
(c) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/6, 19 59, to 12/17, 19 59, that I last saw the deceased alive on 12/17, 19 59, and that death occurred at 5:50 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John A. Fischer M.D. | | ADDRESS (Street, city or town, state) 162 W. MAIN ST. ELKTON, MD | |
| PHYSICIAN'S NAME (Type) John A. Fischer | | DATE SIGNED 12/18/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF DEC 23, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY CHERRY HILL | | 22d. LOCATION (City, town, or county) (State) CHERRY HILL, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE PAPPIN FUNERAL HOME | | 24a. REC'D BY REGISTRAR DATE DEC 30 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF AGENT

1961

1961

TO THE DIRECTOR, FBI
FROM THE SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph report.]

[Illegible text in the right margin, possibly a file number or reference.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13607

Reg. Dist. No. 96

13631

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>
c. LENGTH OF STAY IN 1b <u>5 minutes</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VAH, Perry Point, Maryland</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>
d. STREET ADDRESS _____
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>Harry</u> Last <u>HOFFMAN</u> | | | | 4. DATE OF DEATH
Month <u>12</u> Day <u>15</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<u>5-8-83</u> | | 9. AGE (In years last birthday) <u>76</u> yrs.
IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Regular laborer</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pickway, Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Samuel W. Hoffman</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary E. Alexander</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>214-12-0879</u> | | | | 17. INFORMANT <u>Mrs. Charles McCauley, North East, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>3 Cerebral arteriosclerosis, bilateral thrombosis 10 yrs.</u>
DUE TO (b) <u>1. Bronchopneumonia right lower & middle lobes 36-48 hrs.</u>
DUE TO (c) <u>2. Arteriosclerotic heart disease unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized severe</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>R. C. DODSON, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <u>12-15-59</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/18/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Northeast METHODIST</u> | | 22d. LOCATION (City, town, or county) (State)
<u>North East, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>JOSEPH R. GRANT, Northeast, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 21 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Grant</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

CERTIFICATE OF DEATH

Reg. Dist. No.

13608

| | | | | | | | |
|---|------------------------|--|-------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Katherine L. Holding | | | | 4. DATE OF DEATH Month Day Year Dec. 18 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 3, 1895 | | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Chester Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Parker | | | | 14. MOTHER'S MAIDEN NAME Ella M. Tamey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address George R. Holding Warwick Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old CVA (cerebro-vascular accident)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 10 min
1 year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Completely paralyzed left side. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 18 Dec 59 to 18 Dec 59, 1959, that I last saw the deceased alive on 18 Dec 59, 12:00noon, and that death occurred at M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 21 Dec 59 | | | | | | | |
| ACTUAL SIGNATURE Wallace Obenshain M.D. | | | | DATE SIGNED 21 Dec 59 | | | |
| PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | | | | Cecilton, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-21-59 | | 22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery | | 22d. LOCATION (City, town, or county) (State) Galena Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington, Md. | | | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

1918

| | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| John Doe | | Male | | 35 | | Jan 1, 1883 | | Maryland | |
| MARRIAGE | | SINGLE | | MARRIED | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | |
| None | | None | | None | | None | | None | |
| EDUCATION | | SCHOOLING | | SCHOOLING | | SCHOOLING | | SCHOOLING | |
| High School | | High School | | High School | | High School | | High School | |
| OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | | OCCUPATION | |
| Farmer | | Farmer | | Farmer | | Farmer | | Farmer | |
| CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | | CAUSE OF DEATH | |
| Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | |
| DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | | DATE OF DEATH | |
| Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | |
| PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | | PLACE OF DEATH | |
| Home | | Home | | Home | | Home | | Home | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| J. Doe | | J. Doe | | J. Doe | | J. Doe | | J. Doe | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | |
| SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | | SIGNATURE OF REGISTRAR | |
| J. Doe | | J. Doe | | J. Doe | | J. Doe | | J. Doe | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | | Jan 15, 1918 | |

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13632 CERTIFICATE OF DEATH

13609

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|--|---------------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN North East | | LENGTH OF STAY (in this place)
25 years | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Rural North East | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
- | | | | STREET ADDRESS (If rural give location)
/ | | | |
| 3. NAME OF DECEASED
(Type or Print) Rudolph E. Jernstrom | | | | 4. DATE OF DEATH
(Month) 12 (Day) 19 (Year) 1959 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Married | 8. DATE OF BIRTH
6-25-1902 | 9. AGE last birthday
57 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Building | | 11. BIRTHPLACE (State or foreign country)
Finland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Anders W. Jernstrom | | | | 14. MOTHER'S MAIDEN NAME
Eva Nyberg | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)
no | | 16. SOCIAL SECURITY NO.
214-18-2696 | | 17. INFORMANT & ADDRESS
Hilma Leivonen Jernstrom North East, Md | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) Acute Coronary Thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
(1) hour | |
| ANTECEDENT CAUSE(S) DUE TO (B) Aortic Insufficiency | | | | | | (9) months | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertrophy of Heart | | | | | | (9) months | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.
None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21a. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from March 3, 1959, to Dec. 19, 1959, that I last saw the deceased alive on Dec. 11 1959, and that death occurred at 8:20 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
James L. Johnson | | | | ADDRESS (Street, city, town, state)
M.D. 245 E. High, St. Elkton, Md. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | DATE THEREOF
12-23-1959 | | LOCATION (City, town, or county) (State)
North East, Cecil Co., Md | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
Arthur S. Knecht | | 25. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Grant | | ADDRESS
North East, Maryland | |
| DATE
DEC 23 '59 | | | | | | | |

13633

CERTIFICATE OF DEATH

Reg. Dist. No. 96

| | | | | | |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia COUNTY <input checked="" type="checkbox"/> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First GUY Middle (NMI) Last KINZER | | | 4. DATE OF DEATH
Month December Day 10 Year 19 59 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-18-88 | | 9. AGE (In years last birthday)
71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
James H. Kinzer | | |
| 14. MOTHER'S MAIDEN NAME
Mary F. Kiyle | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | |
| 16. SOCIAL SECURITY NO.
WW I | | | 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infarction hemorrhagic of the heart
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO
(c) unknown | | | | | INTERVAL BETWEEN ONSET AND DEATH
3-4 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from January 18, 1957 to December 10, 1959 and that death occurred at 11:20 AM , from the causes and on the date stated above. | | | |
| 21. ADDRESS (Street, city or town, state)
V.A. Hospital, Perry Point, Md. | | 21. DATE SIGNED
12-11-59 | | | |
| 22a. ACTUAL SIGNATURE
J. L. GAREY | | 22b. PHYSICIAN'S NAME (Type)
J. L. GAREY | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son | | 23a. ADDRESS
Havre de Grace, Md. | | 23b. REC'D BY REGISTRAR
DEC 17 '59 | |
| 23c. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13619

Item 3 Film G254 12-30-59 et

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | c. LENGTH OF STAY IN 1b
<u>20 minutes</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North East</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Union Hospital</u> | | | | / d. STREET ADDRESS
<u>R.D.1.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>James Graham Thomas Knight</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>12 15 19 59</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 30, 1895</u> | | 9. AGE (In years last birthday)
<u>64</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Lumberman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Lumber Lab.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Thomas Knight</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Allen Stewart</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>210-32-4186</u> | | 17. INFORMANT (Daughter) <u>Perryville, Md. Rural</u>
<u>Jessie E. Burlin. North East, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis</u>
(c), stating the underlying cause lost. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
<u>19</u> | Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>R. C. Dodson</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>R. C. Dodson</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>12-16-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12-18-1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Darlington</u> | | 22d. LOCATION (City, town, or county)
<u>Darlington, Md.</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. A. Patterson & Son</u> | | | | ADDRESS
<u>Perryville, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE DEC 21 '59 | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kears</u> |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED
JAMES J. JONES | | 2. SEX
Male | | 3. AGE
45 | |
| 4. OCCUPATION
Carpenter | | 5. MARITAL STATUS
Married | | 6. PLACE OF BIRTH
New York, N.Y. | |
| 7. DATE OF DEATH
Jan 15, 1941 | | 8. TIME OF DEATH
10:30 A.M. | | 9. PLACE OF DEATH
Home | |
| 10. CAUSE OF DEATH
Myocardial Infarction | | 11. MANNER OF DEATH
Natural | | 12. SIGNATURE OF EXAMINER
[Signature] | |
| 13. SIGNATURE OF NEXT OF KIN
[Signature] | | 14. SIGNATURE OF PHYSICIAN
[Signature] | | 15. SIGNATURE OF CORONER
[Signature] | |
| 16. SIGNATURE OF JURY
[Signature] | | 17. SIGNATURE OF WITNESSES
[Signature] | | 18. SIGNATURE OF DECEASED
[Signature] | |
| 19. SIGNATURE OF BURIAL OFFICIAL
[Signature] | | 20. SIGNATURE OF FUNERAL HOME
[Signature] | | 21. SIGNATURE OF CEMETERY
[Signature] | |
| 22. SIGNATURE OF CHURCH
[Signature] | | 23. SIGNATURE OF MINISTERS
[Signature] | | 24. SIGNATURE OF OTHER
[Signature] | |
| 25. SIGNATURE OF OTHER
[Signature] | | 26. SIGNATURE OF OTHER
[Signature] | | 27. SIGNATURE OF OTHER
[Signature] | |
| 28. SIGNATURE OF OTHER
[Signature] | | 29. SIGNATURE OF OTHER
[Signature] | | 30. SIGNATURE OF OTHER
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| 31. SIGNATURE OF OTHER
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| 34. SIGNATURE OF OTHER
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| 37. SIGNATURE OF OTHER
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| 40. SIGNATURE OF OTHER
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| 43. SIGNATURE OF OTHER
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| 46. SIGNATURE OF OTHER
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| 49. SIGNATURE OF OTHER
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| 52. SIGNATURE OF OTHER
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| 55. SIGNATURE OF OTHER
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| 58. SIGNATURE OF OTHER
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| 61. SIGNATURE OF OTHER
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| 64. SIGNATURE OF OTHER
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| 67. SIGNATURE OF OTHER
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| 70. SIGNATURE OF OTHER
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| 73. SIGNATURE OF OTHER
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| 76. SIGNATURE OF OTHER
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| 79. SIGNATURE OF OTHER
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| 82. SIGNATURE OF OTHER
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| 85. SIGNATURE OF OTHER
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| 88. SIGNATURE OF OTHER
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| 91. SIGNATURE OF OTHER
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| 94. SIGNATURE OF OTHER
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[Signature] | | 96. SIGNATURE OF OTHER
[Signature] | |
| 97. SIGNATURE OF OTHER
[Signature] | | 98. SIGNATURE OF OTHER
[Signature] | | 99. SIGNATURE OF OTHER
[Signature] | |
| 100. SIGNATURE OF OTHER
[Signature] | | 101. SIGNATURE OF OTHER
[Signature] | | 102. SIGNATURE OF OTHER
[Signature] | |

13634

CERTIFICATE OF DEATH

Reg. Dist. No.

13612

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> | | b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Colora - Rural</u> | | c. LENGTH OF STAY IN lb
<u>Life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Colora - Rural</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
<u>1</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John William Liddell</u> | | | | 4. DATE OF DEATH
Month <u>Dec.</u> Day <u>-3-</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 17, 1904</u> | |
| 9. AGE (In years last birthday)
<u>55</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Harford Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Henry Liddell</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Clara H. Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
(If yes, give year or dates of service) <u>220-20-93</u> | | 17. INFORMANT
<u>Miss Clara Liddell Colora, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>
<u>155.1</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Gall Bladder</u>
DUE TO
(c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month <u>19</u>
Day <u>19</u>
Year <u>1959</u>
Hour <u>11</u> o. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>Dec 3, 1959</u> , that I last saw the deceased alive on <u>Nov 3, 1959</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Colora - Md.</u> DATE SIGNED <u>Arthur S. Knaus</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/6/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>West Nottingham Cem. Colora Md.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Thomas E. McMillen</u> | | | | ADDRESS
<u>Rising Sun, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 7 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Knaus</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13635
CERTIFICATE OF DEATH

13613

Reg. Dist. No. 96

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Pennsylvania
b. COUNTY
Wilkes-Barre, 75x-3 | |
| c. LENGTH OF STAY IN 1b
10yrs.3mo.12days | | d. STREET ADDRESS
312 E. Northampton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
LOUISE
Middle
F.
Last
MELLIES | | 4. DATE OF DEATH
Month
December
Day
14
Year
1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-12-77 |
| 9. AGE (In years lost birthday)
82 yrs. | | 10. IF UNDER 1 YEAR
Months
82 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY
Nursing | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frederick Mellies | | 14. MOTHER'S MAIDEN NAME
Pauline Muhlic | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 581.0 Azotemia uremia (clinical)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cirrhosis of the liver
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe | | | |
| INTERVAL BETWEEN ONSET AND DEATH
5-6 days
unknown | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 2, 1949 , to December 14, 1959 and that death occurred at 3:00a , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 12-14-59 | | | |
| ACTUAL SIGNATURE
J. L. Garey | | PHYSICIAN'S NAME (Type)
J. L. GAREY
Clinical Pathologist | |
| 22a. BURIAL/CREMATION REMOVAL (Specify)
12/15/59 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hollenback | | 22d. LOCATION (City, town, or county) (State)
Wilkes-Barre, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son | | ADDRESS
Havre de Grace, Md. | |
| 24a. REC'D BY REGISTRAR
DATE DEC 17 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

2

VS A15 (4)
15M 9/58

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13614

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, Maryland | | c. LENGTH OF STAY IN 1b
51 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
VA Hospital, Perry Point, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HARRY Middle MILLER Last | | 4. DATE OF DEATH
Month December Day 4 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 5, 1895 |
| 9. AGE (In years lost birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months 63 Days 63 Hours 63 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 11. BIRTHPLACE (State or foreign country)
McDowell, West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Milton Miller | | 14. MOTHER'S MAIDEN NAME
Agnes Cole | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. ADDRESS
Hospital records, VAH-Perry Point, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerosis, generalized, severe
DUE TO
(c) Adenocarcinoma of the prostate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Adenocarcinoma of the prostate | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-4-59 to 12-4-59 , and that death occurred at 6:00 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
J. L. Garey | | ADDRESS (Street, city or town, state)
VAH., Perry Point, Md. | |
| PHYSICIAN'S NAME (Type)
J. L. GAREY, MD | | DATE SIGNED
12-4-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
12/8/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington, National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fennington & Son | | ADDRESS
Havre de Grace, Md. | |
| 24a. RECEIVED BY REGISTRAR
DEC 10 59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanes | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

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[illegible][illegible]

400

WILEY-ROBINSON

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

25. *Journal of the American Medical Association*, 279:1223-1224, 1997

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

CERTIFICATE OF DEATH

Reg. Dist. No. 96

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN 1b <u>34 days</u> | | d. STREET ADDRESS <u>2711 Ft. Baker Drive, S.E.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>M.</u> Last <u>MOORE</u> | | 4. DATE OF DEATH
Month <u>December</u> Day <u>22</u> Year <u>19 59</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-21-87</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Book Binding</u> | 11. BIRTHPLACE (State or foreign country) <u>Texas</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Ransome Moore (Deceased)</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Martha E. Moroney (Deceased)</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | |
| 16. SOCIAL SECURITY NO. <u>WW I 486-10-4286</u> | | INFORMANT Address <u>Hospital Records, VAH, Perry Point, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, left lower lobe, unresolved</u>
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic heart disease</u>
DUE TO
(c) <u>unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized severe</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> <u>VA</u> <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>November 18, 1959</u> to <u>December 22, 1959</u> and that death occurred at <u>4:15 p.m.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>12-23-59</u> | | | |
| ACTUAL SIGNATURE <u>J. L. Garey</u> | | PHYSICIAN'S NAME (Type) <u>J. L. GAREY</u> | |
| 22a. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Fun. Home, 517-11th St. S.E. Wash. DC</u> | | 24a. REGISTERAR'S SIGNATURE <u>Arthur L. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of New York

County of ...

Decedent's Name ...

Age ...

Sex ...

Date of Birth ...

Place of Birth ...

Cause of Death ...

Time of Death ...

Place of Death ...

Signature of Physician ...

Signature of Coroner ...

Signature of Registrar ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 1-14-60 et

13638

CERTIFICATE OF DEATH

Reg. Dist. No.

13616
96

| | | | |
|---|------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 22yrs.10mo.9days Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 1127 Fifth Street, N.W. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle A. Last ORMES | | 4. DATE OF DEATH Month December Day 17 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-12-73 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs | |
| 11. BIRTHPLACE (State or foreign country) Iowa | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Not ascertainable | | 14. MOTHER'S MAIDEN NAME Not ascertainable | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Informant Address Hospital Records, VAH, Perry Point, Md. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 196.9 Bronchopneumonia bilateral unresolved
DUE TO (b) Osteogenic sarcoma with chest metastasis,
splenic and gall bladder
(c) Atherosclerosis of aortic & mitral valves with stenosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Arteriosclerosis of coronary artery without cardiac symp- | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) toms | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 8, 1937, to December 17, 1959, and that death occurred at 1:12 p.m., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Louis G. Cian M.D. V.A. Hospital, Perry Point, Md. 12-18-59
PHYSICIAN'S NAME (Type) LOUIS G. CIAN Staff Surgeon | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 12/21/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fernington & Son | | ADDRESS Havre de Grace, Md. | |
| 24a. REC'D BY REGISTRAR DATE DEC 29 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

STATE OF TEXAS
COUNTY OF DALLAS

1933

1

John A. ...

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

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|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point
c. LENGTH OF STAY IN 1b
11yrs. 1mo. 9days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
Virginia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Alexandria
d. STREET ADDRESS
202 S. Fayette
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
CHARLES (NMI) SIBERT | | 4. DATE OF DEATH
Month Day Year
December 14 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-21-84 |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman | | 10b. KIND OF BUSINESS OR INDUSTRY
Public School | |
| 11. BIRTHPLACE (State or foreign country)
Missouri | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Not available in records | | 14. MOTHER'S MAIDEN NAME
Not available in records | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 5, 1948 to December 14, 1959 that he was deceased on December 14, 1959 and that death occurred at 9:30 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE
J. L. Garey | | M.D. V.A. Hospital, Perry Point, Md. | |
| PHYSICIAN'S NAME (Type)
J. L. GAREY | | Clinical Pathologist | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
12/18/59 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Penningson & Son | | ADDRESS
Havre de Grace, Md. | |
| 24a. REC'D BY REGISTRAR
DEC 29 1959 | | DATE | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hirsch | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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CERTIFICATE OF DEATH

Reg. Dist. No.

14357

13620

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|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton 21</u>
d. STREET ADDRESS <u>151 West High St</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Daniel Z Simmons</u>
First Middle Last
4. DATE OF DEATH <u>Dec 27 1959</u>
Month Day Year | | 5. SEX <u>male</u>
6. COLOR OR RACE <u>white</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>April 7, 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter - Ship</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>John Simmons</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>
16. SOCIAL SECURITY NO. <input type="checkbox"/>
17. BIRTHPLACE (State or foreign country) <u>Maryland</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u>
DUE TO
(c) <u>Suprapubic Prostatectomy</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dec 27/59</u>
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> | | 14. MOTHER'S MAIDEN NAME <u>Elisa Miller</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>Dec 8, 1959</u> to <u>Dec 27, 1959</u> , that I last saw the deceased alive on <u>Dec 27, 1959</u> , and that death occurred at <u>10:00 PM</u> from the causes and on the date stated above.
ACTUAL SIGNATURE <u>H. Arthur Cantwell</u> M.D. ADDRESS <u>North East, Md.</u> DATE SIGNED
PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell North East, Md.</u> | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>
22b. DATE THEREOF <u>12/30/59</u>
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, Elkton, Md.</u>
24a. REC'D BY REGISTRAR <u>Jan 6 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

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TO HOSPITAL 24 HOURS AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

13640

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun | | c. LENGTH OF STAY IN lb 5 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Buckley Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle E. Last STOUGH | | 4. DATE OF DEATH December 20 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 12, 1894 |
| 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) York County, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Solomon Eisenhower | | 14. MOTHER'S MAIDEN NAME Sarah Wilhelm | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Harold R. David | | Address Rising Sun, Md. 17 Buckley Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 453.3 DUE TO Pulmonary Infarction
(b) Acute thrombophlebitis
(c) Peripheral vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 hours
4 days
3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed ridden due to hip fracture | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5, 1958, to 12/20, 1959, that I last saw the deceased alive on 12/20, 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Neil Taylor | | DATE SIGNED 12/20/59 | |
| PHYSICIAN'S NAME (Type) Neil Taylor Jr | | ADDRESS (Street, city or town, state) Rising Sun, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 23 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Shiloh Union Cemetery | | 22d. LOCATION (City, town, or county) York County, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson | | ADDRESS, Rising Sun, Md. | |
| 24a. REC'D BY REGISTRAR DATE DEC 22 '59 | | 24b. REGISTRAR'S SIGNATURE | |

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13621

CERTIFICATE OF DEATH

13619

Reg. Dist. No.

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|---|--|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Likton | | | | c. LENGTH OF STAY IN TB 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Clauss Middle Tassick Last Tassick | | | | 4. DATE OF DEATH
Month Dec. Day 7 Year 59 | | | |
| 5. SEX
male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> RE-MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
1892 | | 9. AGE (In years last birthday)
67 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm Work | | 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
Unknown ✓ | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
O.B. Wilson | | Address
Colora, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia
446X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia
DUE TO (c) Nephrosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
2 wks
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized Arteriosclerosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. — 19 | Month — Day — Year 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from 5 Dec., 1959 to 7 Dec., 1959 , that I last saw the deceased alive on 7 Dec., 1959 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Klaus H. Huebner | | M.D. | | ADDRESS (Street, city or town, state)
North East, Md. | | DATE SIGNED
7 Dec '59 | |
| PHYSICIAN'S NAME (Type)
Klaus H. Huebner | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Dec 10, 1959 | 22c. NAME OF CEMETERY OR CREMATORY
West Nottingham | | 22d. LOCATION (City, town, or county)
Colora | | (State)
Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Earl Tyson | | | | ADDRESS
Rising Sun, Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 10 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hanes |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

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|---|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 | |
| 4. DATE OF BIRTH
May 19, 1916 | | 5. PLACE OF BIRTH
Jackson, Mississippi | | 6. RACE
White | |
| 7. DATE OF DEATH
April 4, 1968 | | 8. PLACE OF DEATH
Memphis, Tennessee | | 9. CAUSE OF DEATH
Gunshot wound | |
| 10. MANNER OF DEATH
Homicide | | 11. ICD-9 CODE
270.91 | | 12. ICD-10 CODE
R01.01 | |
| 13. NAME OF PHYSICIAN
Dr. J. H. Smith | | 14. NAME OF HOSPITAL
St. Francis Hospital | | 15. NAME OF NURSE
Mrs. J. K. Brown | |
| 16. NAME OF FUNERAL HOME
The Funeral Home | | 17. NAME OF BURIAL PLACE
Greenwood Cemetery | | 18. NAME OF MINISTER
Rev. J. L. White | |
| 19. NAME OF NEXT OF KIN
Mrs. J. K. Brown | | 20. ADDRESS
123 Main St., Baltimore, Md. | | 21. CITY
Baltimore | |
| 22. STATE
Maryland | | 23. COUNTY
Baltimore | | 24. ZIP CODE
21201 | |
| 25. SIGNATURE OF PHYSICIAN
J. H. Smith | | 26. SIGNATURE OF HOSPITAL
St. Francis Hospital | | 27. SIGNATURE OF NURSE
Mrs. J. K. Brown | |
| 28. SIGNATURE OF FUNERAL HOME
The Funeral Home | | 29. SIGNATURE OF BURIAL PLACE
Greenwood Cemetery | | 30. SIGNATURE OF MINISTER
Rev. J. L. White | |
| 31. SIGNATURE OF NEXT OF KIN
Mrs. J. K. Brown | | 32. SIGNATURE OF DECEASED
James Earl Ray | | 33. SIGNATURE OF WITNESSES
J. K. Brown, J. L. White | |

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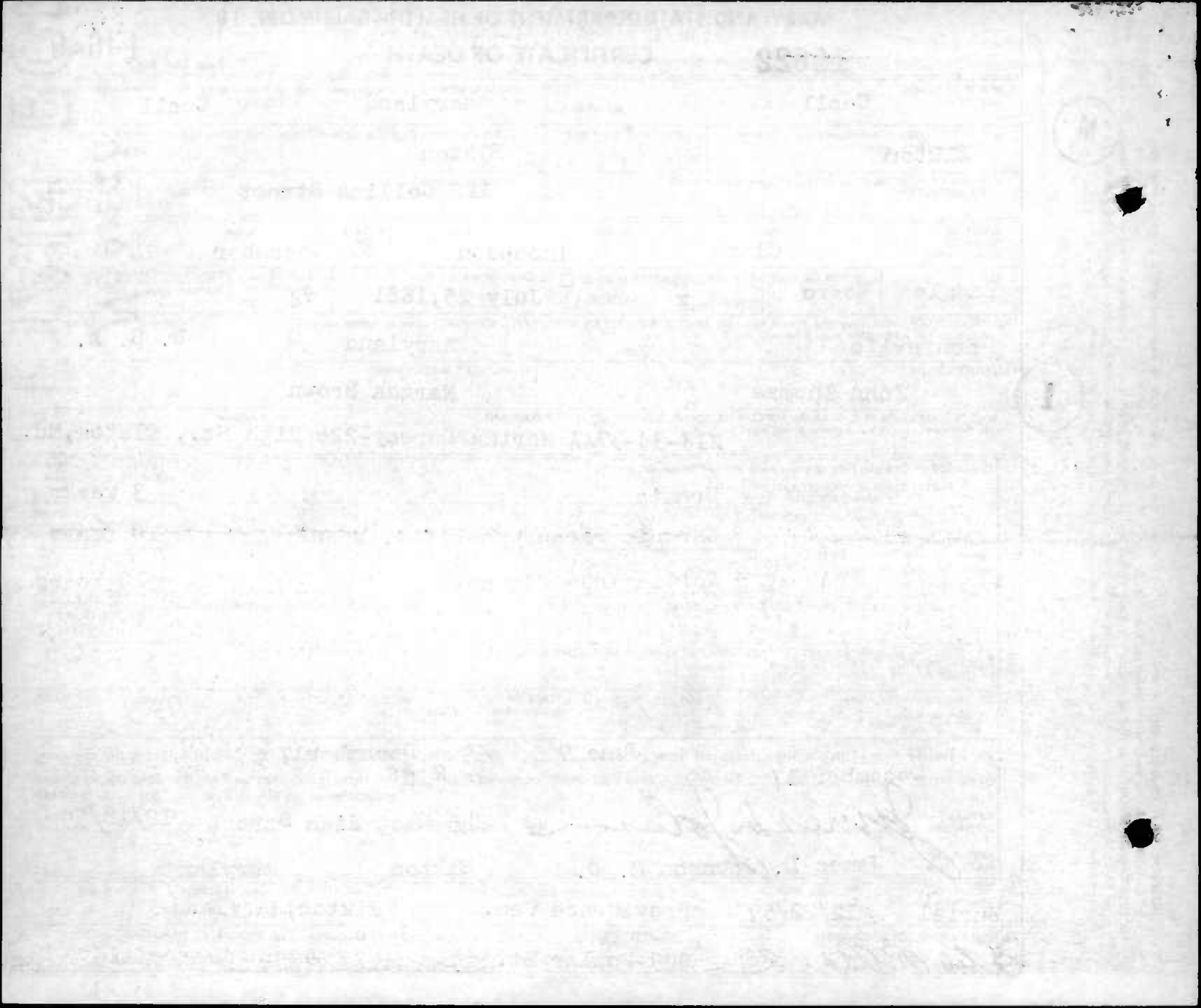
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1 13622 Item 1 Film G254 1-4-60 et 13620 13622 MARYLAND STATE DEPARTMENT OF RESIDENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No.

| | | | |
|---|----------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home | | d. STREET ADDRESS 1 122 Collins Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clara Thompson | | 4. DATE OF DEATH Month Day Year December 18 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 25, 1881 |
| 9. AGE (In years last birthday) 78 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Thomas | | 14. MOTHER'S MAIDEN NAME Martha Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 218-38-3744 | |
| 17. INFORMANT Address Martha Dorsey-226 High St., Elkton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
593X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Parencephalitis, Nephritis
DUE TO
(c) Aortic Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks
10 Years
10 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 9, 1959, to December 17, 1959, that I lost the deceased alive on December 17, 1959, and that death occurred at 2 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James L. Johnson M.D. | | ADDRESS (Street, city or town, state) 245 East High Street 12/18/59 DATE SIGNED | |
| PHYSICIAN'S NAME (Type) James L. Johnson M. D. | | Elkton Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12/23/59 | 22c. NAME OF CEMETERY OR CREMATORY Providence Cem. | 22d. LOCATION (City, town, or county) (State) Elkton, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Elmer P. Bell | | ADDRESS 909 Poplar St. | |
| 24a. REC'D BY REGISTRAR DATE DEC 22 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 96

13641

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|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
1 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First QUINCY Middle SUE Last TING | | 4. DATE OF DEATH
Month December Day 10, Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
Yellow | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-26-91 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 68 Days 68 Hours 68 Min. | 11. IF UNDER 24 HRS.
Months 68 Days 68 Hours 68 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Head Waiter | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 11. BIRTHPLACE (State or foreign country)
California | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank Que Duck | | 14. MOTHER'S MAIDEN NAME
Jont Shee Quon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW-I 123-10-0537 | |
| 17. INFORMANT
Hospital Records, VA Hospital, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia bilateral, unresolved
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombophlebitis left femoral vein
DUE TO
(c) Gangrene of the left lower extremity | | INTERVAL BETWEEN ONSET AND DEATH
3-4 days
unknown
unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 9, 1959 , to December 10, 1959 at VA Hospital, Perry Point, Md. that death occurred at 6:26 a.m. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE
J. L. Garey | | M.D. V.A. Hospital, Perry Point, Md. 12-11-59 | |
| PHYSICIAN'S NAME (Type)
J. L. GAREY | | Clinical Pathologist | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 22b. DATE THEREOF
12/16/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Ft. Myer, Virginia. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
PENNINGTON & SON | | ADDRESS
Havre DeGrace, Md. | |
| 24a. REC'D BY REGISTRAR
DEC 17 '59 | | 24b. REGISTRAR'S SIGNATURE
C. S. Thomas | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

RECEIVED JAN 20 1947

I have

received your letter of the 17th

and am sorry to hear of your

illness. I hope you will

be able to return to work

soon. I am sure you will

be able to return to work

soon. I am sure you will

be able to return to work

soon. I am sure you will

be able to return to work

soon. I am sure you will

be able to return to work

soon. I am sure you will

be able to return to work

soon. I am sure you will

be able to return to work

CERTIFICATE OF DEATH

Reg. Dist. No.

13642

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point, Maryland | | | | c. LENGTH OF STAY IN 1b
11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
VA, Hospital | | | | / d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Edward W. WHITLOCK | | | | 4. DATE OF DEATH
Month Day Year
December 10 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-1-87 1-24-88 | |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Earlville, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
Earlville, Maryland | |
| 13. FATHER'S NAME
JAMES WHITLOCK | | | | 14. MOTHER'S MAIDEN NAME
Susie Chambers. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
218-10-8367 | | INFORMANT Address
Hospital records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-pneumonia Bilateral, Unresolved
204.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Monocytic Leukemia
DUE TO
(c) Unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - Generalized. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. I certify that death occurred at 12:12AM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
VAH, Perry Point, Maryland | | | | | | | |
| ACTUAL SIGNATURE J. L. Garey | | | | M.D. VAH, Perry Point, Maryland | | | |
| PHYSICIAN'S NAME (Type) J. L. GAREY, MD | | | | Clinical Pathologist | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Dec. 12, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Bethel | | 22d. LOCATION (City, town, or county) (State)
Chesapeake City, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. L. Lushby | | | | ADDRESS
PIPPIN FUNERAL HOME, Elkton Md. | | 24a. REC'D BY REGISTRAR
DATE DEC 15 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hearn | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Death

Residence

Death

1000 11th St

1000 11th St, Washington, D.C.

Decided by

Dr. W. W. WITKOW

Age

1-1-37

White

Male

USA

Residence, Washington

Occupation

Doctor

State of Maryland

Dr. W. W. WITKOW

Hospital records, V.A. Hospital, Md.

2-10-37

W 1

Yes

2-10-37

Residence - 1000 11th St, Washington

1000 11th St

Residence - 1000 11th St, Washington

Autopsy - General

Dr. W. W. WITKOW

Official Pathologist

Dr. W. W. WITKOW

1000 11th St

1000 11th St

1000 11th St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13623**

13643

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cecilton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cecilton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alexander Middle Wilson Last Wilson | | 4. DATE OF DEATH
Month 12 Day 9 Year 19 59 | |
| 5. SEX
M | 6. COLOR OR RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 1876 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months 83 Days 0 Hours 0 Min. 0 | 11. IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Ordinary work | |
| 11. BIRTHPLACE (State or foreign country)
Cecil Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
Cecil Co. Md. | |
| 13. FATHER'S NAME
Charles Wilson | | 14. MOTHER'S MAIDEN NAME
Elizabeth Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Annie Wise | | Address
Cecilton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis Extreme
DUE TO
(c) Arterio Sclerosis Extreme | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerosis Extreme | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour 19 a. m. 0 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
W. C. Dodson | | DATE SIGNED
12-9-59 | |
| EXAMINER'S NAME (Type)
W. C. Dodson M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12/12/59 | 22c. NAME OF CEMETERY OR CREMATORY
Cecilton Cem. | 22d. LOCATION (City, town, or county) (State)
Cecilton Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Edw. R. Bell | | 24a. REC'D BY REGISTRAR
DEC 14 '59 | |
| ADDRESS
909 Poplar St. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

2000

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from 1972 to 1974

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[illegible]

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11 2 2